Please complete payment information. 97 107002

Account No.	Statement Date	Payment Due
96806	2022-04-28	126.35

Mail Pay	Enter Payment Amount	$
by Check	Payable To: INTEGRATED BEHAVIORAL HEALTH	Check No.

Integrated Behavioral Health
600 SUN TEMPLE DR
MADISON, AL 35758-8643
Forward Service Requested

For Billing Inquiries Call: 256-426-9438
Patient: Brent Robeson

054304

TRI90Z 2893804 166096666
Brent Robeson
10719 AL HIGHWAY 101
TOWN CREEK AL 35672-4623

INTEGRATED BEHAVIORAL HEALTH
600 SUN TEMPLE DR
MADISON, AL 35758-8643

☐ Check if your billing information has changed.
Provide update(s) above or on the reverse side.

Please detach and return top portion with payment.

Statement Detail — **Statement Date 2022-04-28** — **Account No. 96806**

Claim No.	Visit Date	Activity Date	Description of Service	Charges	Payments	Balance
635241	2021-04-13	2021-04-13	Claim:635241, Provider: ELIZABETH A SHOEMAKER, LCSW			
635241	2021-04-13	2021-04-13	Facility: IBH of Muscle Shoals			
635241	2021-04-13	2021-04-13	90837 PSYCHOTHERAPY WITH PATIENT 60 MIN	150.01		
635241	2021-01-26	2021-01-26	Patient Payment		8.65	
635241	2021-03-09	2021-03-09	Patient Payment		0.00	
635241	2021-04-26	2021-04-26	HUMANA Payment		60.67	
635241	2021-04-26	2021-04-26	HUMANA Adjustment		54.34	
635241	2022-04-28	2021-04-26	Your Balance Due On These Services ...			26.35
646536	2021-05-06	2021-05-06	Claim:646536, Provider: DEBORAH TYSON, CRNP			
646536	2021-05-06	2021-05-06	Facility: IBH of Muscle Shoals			
646536	2021-05-06	2021-05-06	NOSHO No Sho	50.00		
646536	2022-04-28	2021-05-06	Your Balance Due On These Services ...			50.00
648778	2021-05-11	2021-05-11	Claim:648778, Provider: ELIZABETH A SHOEMAKER, LCSW			
648778	2021-05-11	2021-05-11	Facility: IBH of Muscle Shoals			
648778	2021-05-11	2021-05-11	NOSHO No Sho	50.00		
648778	2022-04-28	2021-05-11	Your Balance Due On These Services ...			50.00

Aging	Current	31 - 60	61 - 90	91 - 120	120+
	0.00	0.00	0.00	0.00	126.35

Payment Due
126.35

FOR CHANGE OF ADDRESS, MISSPELLINGS OR OTHER ERRORS, PLEASE PRINT CORRECTIONS.

Patient's Name			Phone # ( )
Patient's Address	City	State	Zip Code

IF YOU HAVE NOT SUPPLIED INSURANCE INFORMATION, PLEASE DO SO HERE:

PRIMARY INSURANCE COVERAGE	Patient's Relationship to Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Insurance Company Name	Phone # ( )
Insurance Company Address	
Policy Holders Name	Birthdate / /
Policy & Group #	Policy Effective Date / /
Employer's Name	Phone # ( )
Employer's Address	

SECONDARY INSURANCE COVERAGE	Patient's Relationship to Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Insurance Company Name	Phone # ( )
Insurance Company Address	
Policy Holders Name	Birthdate / /
Policy & Group #	Policy Effective Date / /
Employer's Name	Phone # ( )
Employer's Address	